National Survey of Substance Abuse Treatment Services

The N-SSATS Report

April 14, 2011

Differences and Similarities between Urban and Rural Outpatient Substance Abuse Treatment Facilities

In Brief

- The smallest disparities in the provision of ancillary supportive services between rural and urban outpatient facilities involved assistance with obtaining social services (52 vs. 54 percent), domestic violence—family or partner violence services (38 vs. 41 percent), and child care for clients' children (5 vs. 10 percent); the largest disparities involved mentoring/peer support (32 vs. 51 percent), self-help groups (29 vs. 47 percent), and employment counseling or training for clients (25 vs. 40 percent)
- Compared with rural outpatient facilities, urban outpatient facilities were more likely to provide HIV or AIDS education, counseling, or support (63 vs. 43 percent), health education other than HIV/AIDS (58 vs. 35 percent), or early intervention for HIV (34 vs. 15 percent)
- Rural outpatient facilities were more likely than urban outpatient facilities to provide mental health services (64 vs. 56 percent) and were equally likely to provide case management services (80 percent each)

Increasing access to behavioral health care for residents in rural areas is a public health priority aimed at decreasing existing disparities between urban and rural communities. While it is generally accepted that access to quality care is not equally distributed across the United States,[1] there is little national-level research that provides data on the geographical distribution of substance abuse treatment facilities and the services that these facilities provide. In order to fill this gap, this report presents national-level data on the geographic distribution of outpatient substance abuse treatment facilities and the services provided by the facilities located in the most urban and most rural areas. Data from the 2009 National Survey of Substance Abuse Treatment Services (N-SSATS), an annual census of all known facilities in the United States, both public and private, that provide substance abuse

The N-SSATS Report is published periodically by the Center for Behavioral Health Statistics and Quality (formerly the Office of Applied Studies), Substance Abuse and Mental Health Services Administration (**SAMHSA**). For questions about this report, please e-mail: shortreports@samhsa.hhs.gov.

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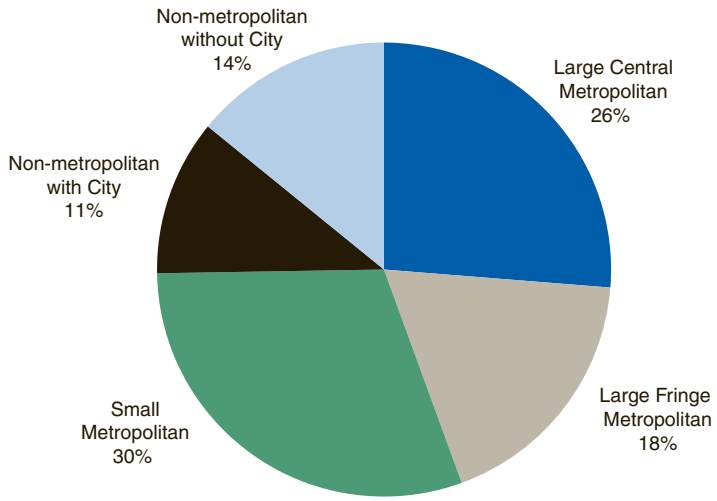
treatment, are used in this report. Approximately 10,900 of the 13,513 substance abuse treatment facilities that responded to the 2009 N-SSATS offered outpatient services. These facilities (hereafter referred to as "outpatient facilities") are the subject of this report.

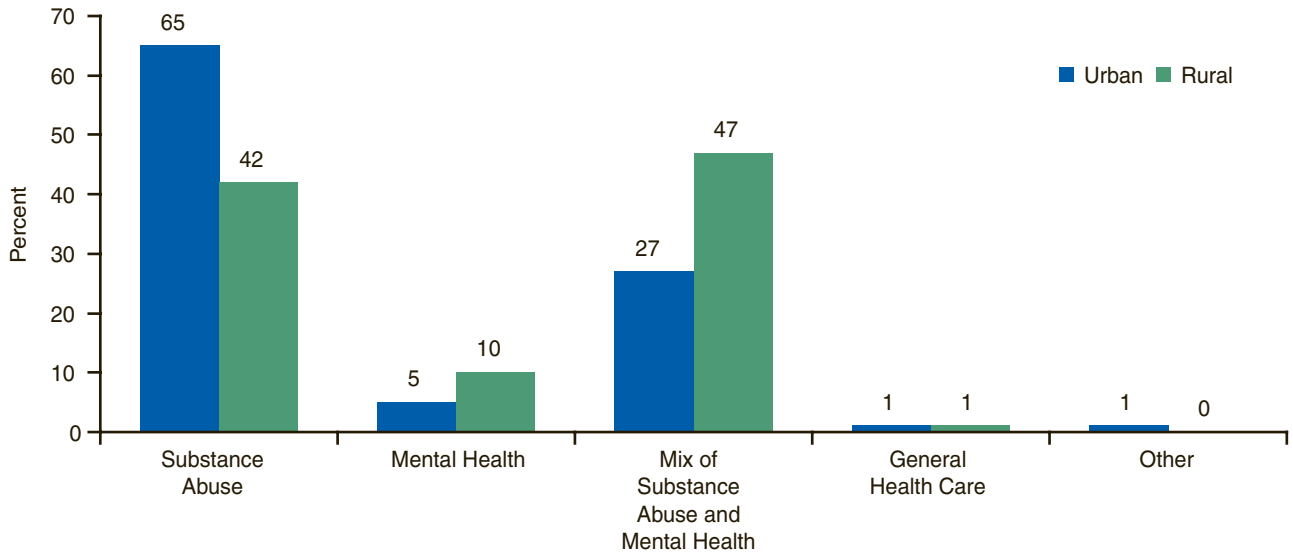
In order to identify rural and urban areas, U.S. counties and county equivalents were assigned to one of five urbanization levels according to the classification scheme developed by the National Center for Health Statistics (NCHS).[2,3] In 2009, over one fourth (26 percent) of outpatient facilities were located in the most urban areas (large central metropolitan areas), and 18 percent were located in large fringe metropolitan areas (Figure 1). Nearly one third (30 percent) were located in small metropolitan areas. Those located in non-metropolitan areas without a city (the most rural areas) represented 14 percent of all outpatient facilities. This report will compare the services provided by facilities located in the most urban areas (large

Figure 1. Distribution of Outpatient Substance Abuse Treatment Facilities, by Urbanization Level: 2009



Note: Percentages may not sum to 100 percent due to rounding.
Source: 2009 SAMHSA National Survey of Substance Abuse Treatment Services (N-SSATS).

Figure 2. Primary Focus of Outpatient Substance Abuse Treatment Facilities, by Urbanization Level: 2009



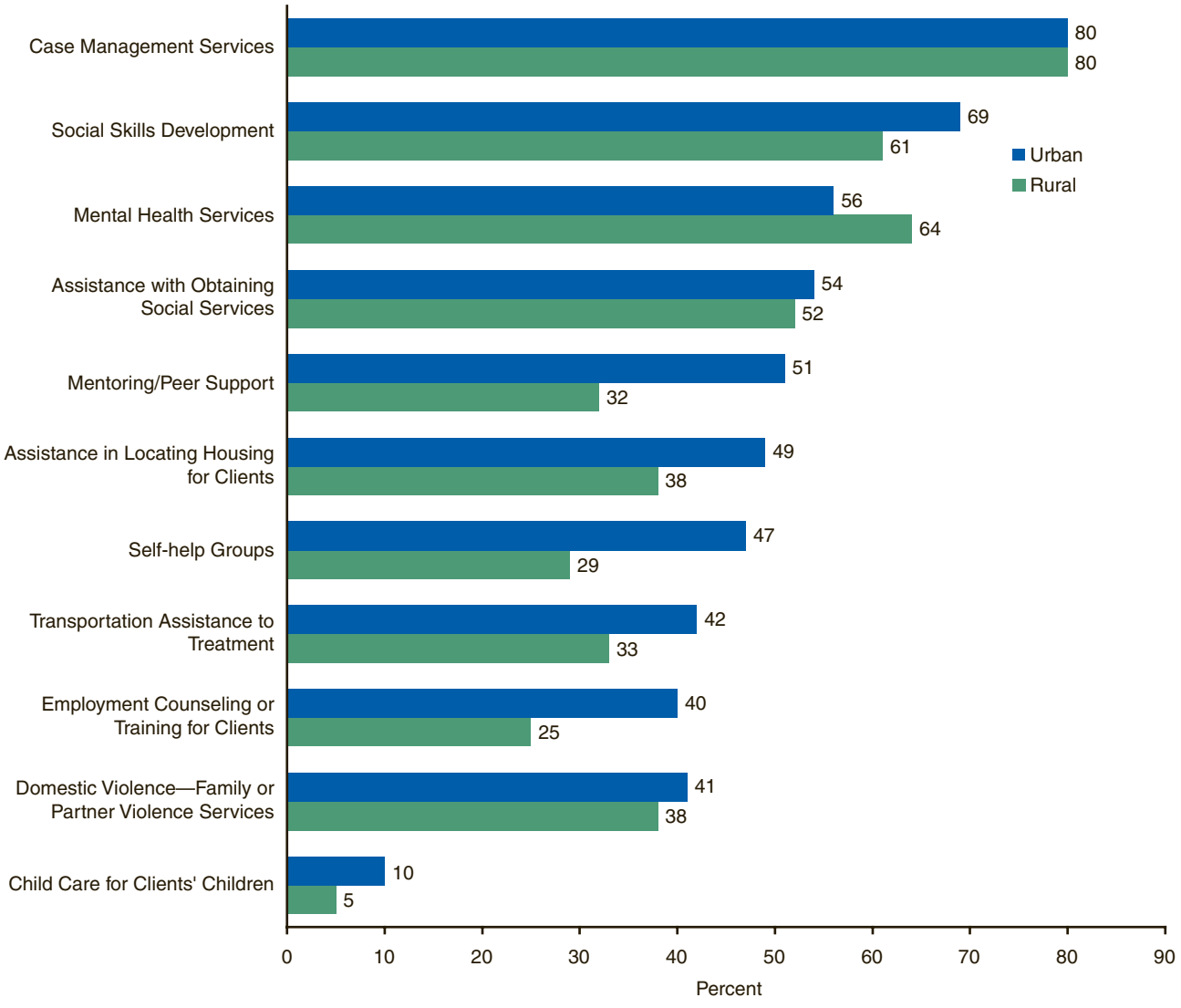
Note: Percentages may not sum to 100 percent due to rounding.
Source: 2009 SAMHSA National Survey of Substance Abuse Treatment Services (N-SSATS).

central metropolitan, hereafter referred to as "urban") with those provided by facilities located in the most rural areas (non-metropolitan without city, hereafter referred to as "rural").

Primary Focus

Substance abuse treatment may be provided by facilities that specialize in substance abuse treatment services or by facilities that have a different primary focus, such as mental health services, a mix of mental health and substance abuse treatment services, general health care, or something else. Outpatient facilities in urban areas were more likely to have a primary focus on substance abuse treatment only (65 percent) than a mix of substance abuse treatment and mental health services (27 percent) (Figure 2). Conversely, rural outpatient facilities were slightly more likely to have a primary focus on a mix of substance abuse treatment and mental health services (47 percent) than substance abuse treatment only (42 percent).

Figure 3. Outpatient Substance Abuse Treatment Facilities Providing Ancillary Supportive Services, by Urbanization Level: 2009



Source: 2009 SAMHSA National Survey of Substance Abuse Treatment Services (N-SSATS).

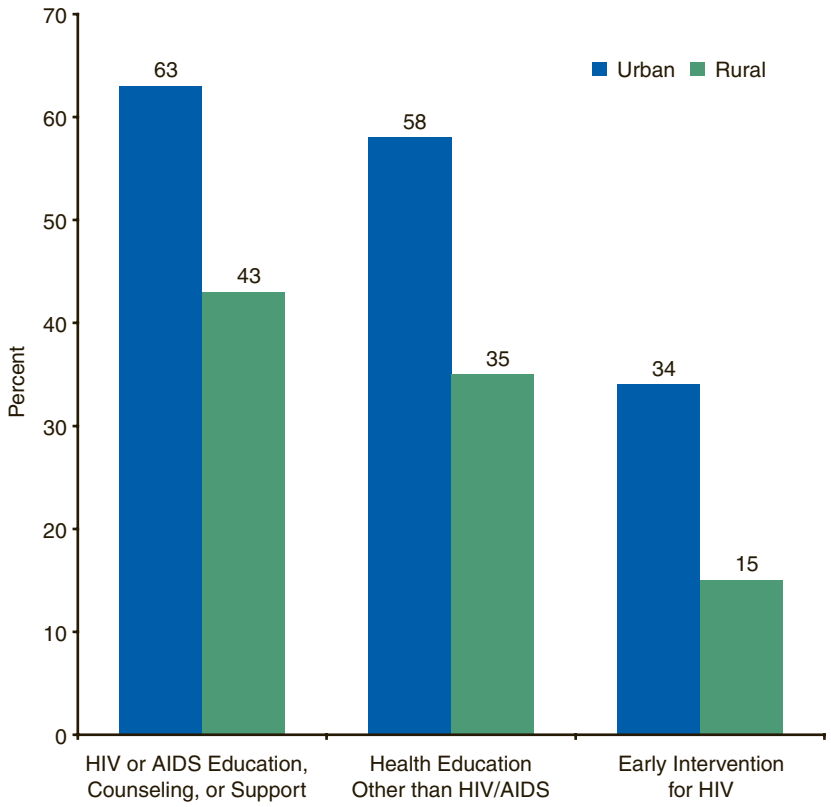
Ancillary Supportive Services

Most substance abuse treatment facilities provide ancillary services that enable participation in treatment and support recovery. Some ancillary services aim to increase clients' self-sufficiency in the community and decrease social barriers to treatment (hereafter referred to as "ancillary supportive services"). For the purposes of this report, ancillary supportive services include mental health services, case management services, assistance with obtaining social services, social skills development, mentoring/peer support, assistance in locating housing for clients, transportation assistance to treatment, employment counseling or training for clients, self-help groups, domestic violence—family or partner violence services, and child care for clients' children.

The provision of ancillary supportive services differed between urban and rural outpatient facilities. Compared with urban facilities, those located in rural areas were less likely to provide any of the ancillary supportive services, with the exception of mental health and case management services. Rural outpatient facilities were more likely than urban outpatient facilities to provide mental health services (64 vs. 56 percent) and equally likely to provide case management services (80 percent each) (Figure 3). The smallest disparities between rural and urban outpatient facilities were in the provision of social services (52 vs. 54 percent), domestic violence—family or partner violence services (38 vs. 41 percent), and child care services (5 vs. 10 percent).

Conversely, the largest disparities between rural and urban outpatient facilities were in the provision of mentoring/peer support (32 vs. 51 percent), self-help groups (29 vs. 47 percent), and employment counseling or training for clients (25 vs. 40 percent).

Figure 4. Outpatient Substance Abuse Treatment Facilities Providing Ancillary Health Services, by Urbanization Level: 2009



Source: 2009 SAMHSA National Survey of Substance Abuse Treatment Services (N-SSATS).

Ancillary Health Services and Infectious Disease Testing

The behaviors associated with injection drug use, such as sharing needles and other drug equipment, place injection drug users at increased risk for spreading or contracting infectious diseases, such as HIV and Hepatitis C. Therefore, substance abuse treatment facilities that include infectious disease testing and prevention/education programs focused on infectious diseases as part of their treatment programs play a vital role in the control,

prevention, and treatment of HIV and other infectious diseases. The provision of infectious disease testing and prevention/education programs differed between urban and rural outpatient facilities. Compared with rural outpatient facilities, urban outpatient facilities were more likely to provide HIV or AIDS education, counseling, or support (63 vs. 43 percent), health education other than HIV/AIDS (58 vs. 35 percent), or early intervention for HIV (34 vs. 15 percent) (Figure 4).

Urban outpatient facilities were also more likely than rural outpatient facilities to provide TB screening (38 vs. 20 percent), STD testing (25 vs. 7 percent), HIV testing (36 vs. 11 percent), or screening for Hepatitis B (25 vs. 11 percent) or Hepatitis C (27 vs. 11 percent) (Figure 5).

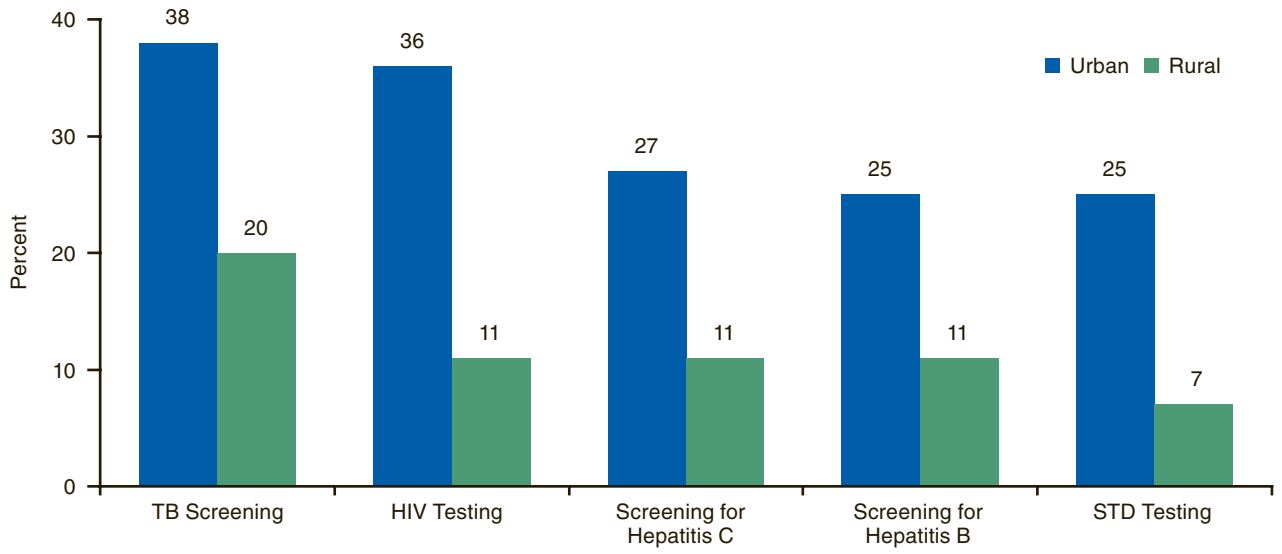
Programs for Specific Types of Clients

N-SSATS obtains information about specially designed programs provided by facilities for the following types of clients: adolescents, clients with co-occurring mental and substance abuse disorders, criminal justice clients (other than DUI/DWI), persons with HIV or AIDS, gays or lesbians, seniors or older adults, adult women, pregnant or postpartum women, and adult men. The provision of specially designed programs for these specific client types differed between urban and rural outpatient facilities. Compared with rural outpatient facilities, urban outpatient facilities were more likely to provide specially designed programs for any of the specified client types except adolescents and criminal justice clients. Rural outpatient facilities were more likely than urban outpatient facilities to provide specially designed programs for adolescents (39 vs. 28 percent) and equally likely to provide such programs for criminal justice clients (29 percent each) (Figure 6).

Sliding Scale Fees and Free Treatment

Unemployment and lack of health insurance are common among persons admitted to substance abuse treatment;[4] therefore, costs of treatment for persons without the means to pay may be entirely or partially covered by government programs and charitable organizations. Consequently, some facilities offer treatment at no charge for clients who

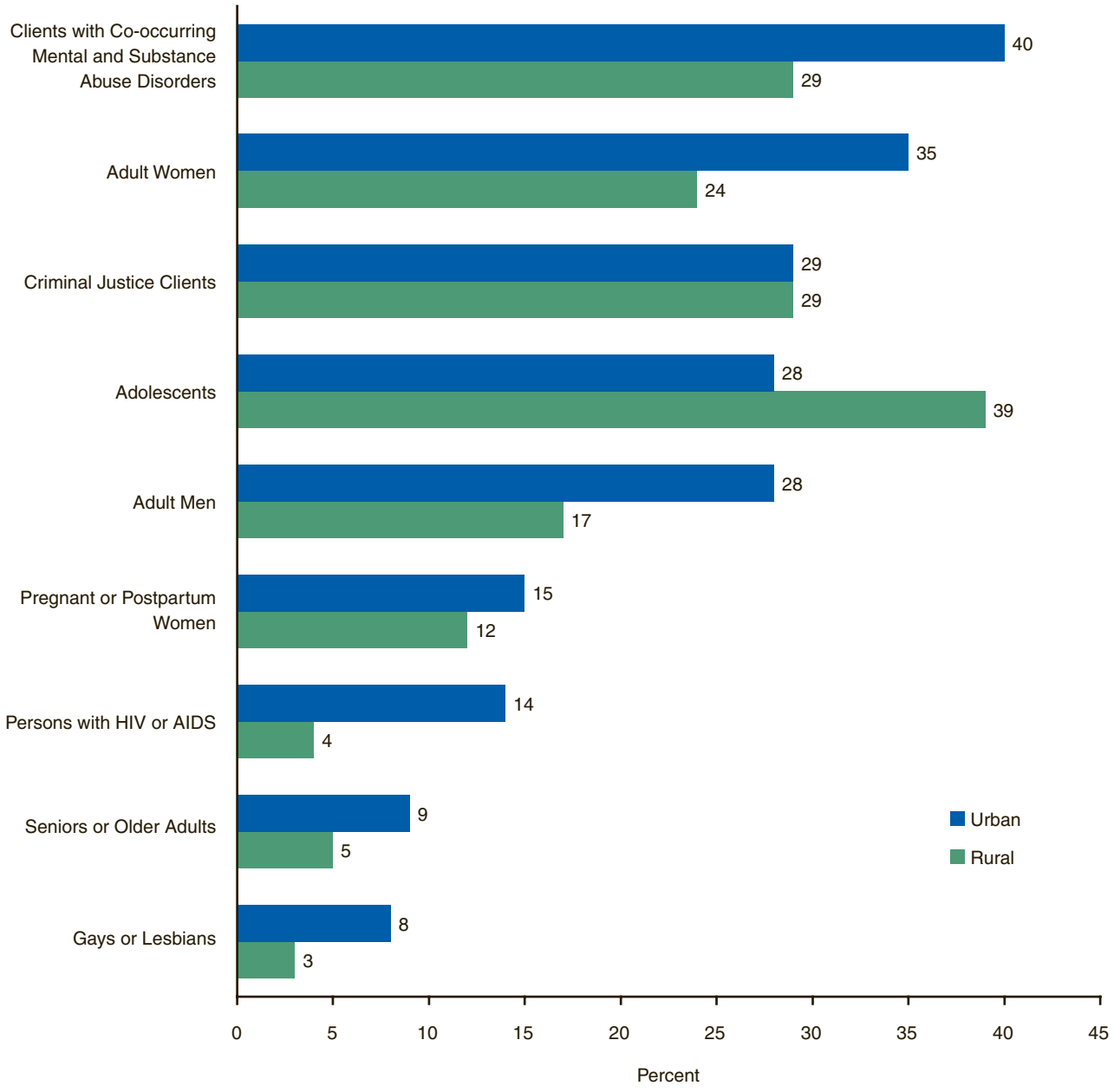
Figure 5. Outpatient Substance Abuse Treatment Facilities Providing Infectious Disease Testing, by Urbanization Level: 2009



Source: 2009 SAMHSA National Survey of Substance Abuse Treatment Services (N-SSATS).

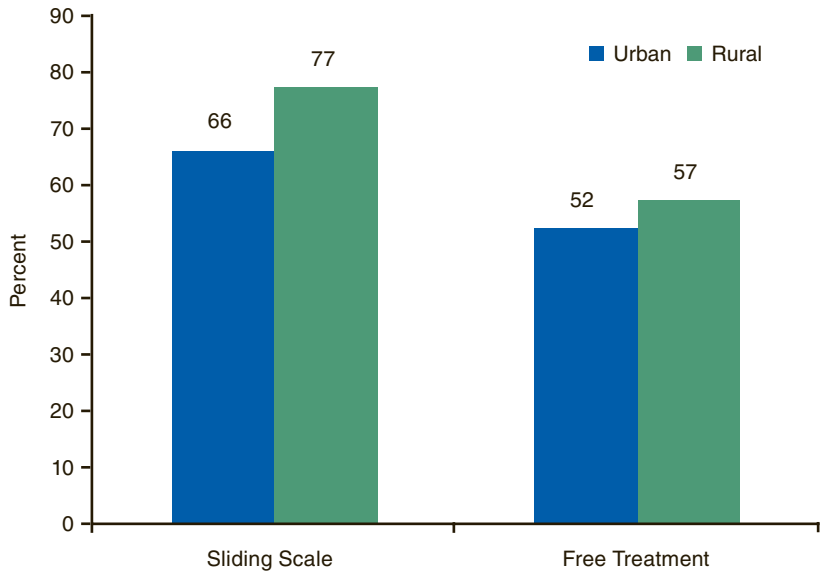
cannot afford to pay and/or a sliding fee scale based on income and other factors. While the majority of outpatient facilities in both urban and rural areas offered treatment at no charge to eligible clients or used a sliding fee scale, rural outpatient facilities were more likely than urban outpatient facilities to offer these types of financial assistance. Of the outpatient rural facilities, 57 percent offered treatment at no charge to eligible clients, and 77 percent used a sliding fee scale (Figure 7). Of the urban outpatient facilities, 52 percent offered free treatment to eligible clients and 66 percent used a sliding fee scale.

Figure 6. Outpatient Substance Abuse Treatment Facilities Offering Specially Designed Programs or Groups for Specific Client Types, by Urbanization Level: 2009



Source: 2009 SAMHSA National Survey of Substance Abuse Treatment Services (N-SSATS).

Figure 7. Outpatient Substance Abuse Treatment Facilities Offering Free Treatment to Clients Who Cannot Afford to Pay or Sliding Scale Fees, by Urbanization Level: 2009



Source: 2009 SAMHSA National Survey of Substance Abuse Treatment Services (N-SSATS).

Discussion

The data presented in this report reveal a variety of differences between outpatient substance abuse treatment services offered in rural and urban communities. These disparities suggest that rural facilities may have access to fewer resources (such as staff and funding) than urban facilities and are therefore less able to provide ancillary health and supportive services and treatment programs designed for specific client types. On the other hand, the data indicate that rural outpatient facilities are more likely than urban facilities to have an integrated treatment approach that focuses on both mental health and substance abuse issues.

Some variation in outpatient substance abuse treatment services between urban and rural facilities is expected because of the inherent differences between the two types of communities and the specific needs facing these various populations. However, disparities may also reflect real inequalities in access to needed services. In order to reduce disparities, the existing gaps in services in each type of community must be identified before policies and programs can be designed to fill those gaps. For example, as noted earlier in this report, urban facilities were less likely to provide mental health services and low cost treatment. Therefore, one effort aimed at decreasing urban-rural disparities could focus on promoting the integration of mental health and substance abuse services and increasing access to low cost treatment in urban communities. Similarly, efforts that are strategically focused on increasing the availability of ancillary supportive services, ancillary health services, and programs designed for specific client types at rural facilities would expand the range of services for clients in treatment in rural communities.

End Notes

[1] Agency for Healthcare Research and Quality. (2005). *Health care disparities in rural areas: Selected findings from the 2004 National Healthcare Disparities Report* (AHRQ Pub No. 05-P022). Retrieved from http://www.ahrq.gov/research/ruraldisp/ruraldispar.pdf

[2] Eberhardt, M. S., Ingram, D. D., Makuc, D. M., Pamuk, E. R., Freid, V. M., Harper, S. B., Schoenborn, C. A., & Xia, H. (2001). Urban and rural health chartbook. In *Health, United States, 2001*. Hyattsville, MD: National Center for Health Statistics.

[3] The classification system used for these reports does not designate any of the five levels as "rural." For the purposes of this report, when the terms "rural" or "most rural" are used, they refer to those counties classified as non-metropolitan without a city of 10,000 or more population, and when the term "urban" or "most urban" is used in this report, it refers to metropolitan counties classified as "large central."

[4] Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2010). *Treatment Episode Data Set (TEDS). 1998-2008. National admissions to substance abuse treatment services* (DASIS Series: S-50, HHS Publication No. (SMA) 09-4471). Rockville, MD: Author.

Suggested Citation

Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (April 14, 2011). *The N-SSATS Report: Differences and Similarities between Urban and Rural Outpatient Substance Abuse Treatment Facilities*. Rockville, MD.

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Findings from SAMHSA's 2009 National Survey of Substance Abuse Treatment Services (N-SSATS)

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The National Survey of Substance Abuse Treatment Services (N-SSATS) is an annual survey of all substance abuse treatment facilities in the United States, both public and private, that are known to the Substance Abuse and Mental Health Services Administration (SAMHSA). N-SSATS is one component of the Drug and Alcohol Services Information System (DASIS), an integrated data system maintained by the Center for Behavioral Health Statistics and Quality, SAMHSA.

N-SSATS collects three types of information from facilities: characteristics of individual facilities such as services offered and types of treatment provided, primary focus of the facility, and payment options; client count information such as counts of clients served by service type and number of beds designated for treatment; and general information such as licensure, certification, or accreditation and facility website availability. In 2009, N-SSATS collected information from 13,513 facilities from all 50 States, the District of Columbia, Puerto Rico, the Federated States of Micronesia, Guam, Palau, and the Virgin Islands. **Information and data for this report are based on data reported to N-SSATS for the survey reference date March 31, 2009.**

The N-SSATS Report is prepared by the Center for Behavioral Health Statistics and Quality, SAMHSA; Synectics for Management Decisions, Inc., Arlington, VA; and RTI International, Research Triangle Park, NC. Information on the most recent N-SSATS is available in the following publication:

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2010). *National Survey of Substance Abuse Treatment Services (N-SSATS): 2009. Data on substance abuse treatment facilities* (DASIS Series: S-54, HHS Publication No. (SMA) 10-4579). Rockville, MD: Author.

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